

Centers for Medicare and Medicaid Services (CMS) Long Term Care Resident Assessment Instrument RAI Version 2.0 Questions and Answers

Preface

This Question and Answer document contains responses to 90 Resident Assessment Instrument (RAI) Version 2.0 questions, directed to the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration. The document begins with general questions about the RAI process. The remaining questions are then arranged by alphabetic section of the RAI form.

This is the third Question and Answer compilation document for version 2.0 formally published by CMS. As such, the question/response sets in this document are numbered 3 – 1 through 3 – 90. The first compilation document was published as “MDS 2.0 Q & A Guide”, in August 1996. The second was published as “MDS 2.0 Q & A Addendum”, in March 2001. The third was published as “MDS 2.0 Q & A Addendum 2”, in July 2001. All three Q & A compilations, as well as individual sets of Q & A's linked to CMS satellite broadcasts, can be downloaded from the CMS web site at:

www.hcfa.gov/medicaid/mds20/res_man.htm

In addition to the Q & A's, use of the Item coding instructions in the RAI User's Manual is essential to accurate MDS coding.

These Q & A's respond to MDS-related inquiries and comments received from a variety of sources, including: 1) inquiries from State and Regional Office staff; 2) results of recent OIG reports; 3) observations from testing new MDS Accuracy Protocols in 30 facilities; and 4) a CMS-sponsored industry-wide survey, which invited questions and comments from the National Provider and Consumer Organizations (i.e., AHCA, AAHSA, AANAC and NCCNHR), from the MDS software vendor community, and from State and Regional Office representatives.

The publication of these Q & A's is only one of a variety of CMS initiatives underway to improve and promote MDS accuracy. Other short-term initiatives include a review of MDS coding instructions at our national RAI conference; revising the RAI User's Manual to incorporate both the Q & A's and new policy implemented since the last publication of the RAI User's Manual in 1995; and the development of MDS Accuracy Protocols for use by a Program Safeguard Contractor in analyzing and verifying MDS data. For the longer term, we are looking at ways to refine the MDS in a way that addresses overall length, clarity, accuracy and clinical utility, for future implementation. In addition, we continue to work with RAI and MDS Automation Coordinators in every State on an on-going basis. These 'local' experts are available to answer MDS related questions.

CMS' MDS 2.0 Q & A Addendum 2

This Q & A compilation is published by CMS and is a public document. It may be copied freely, as our goal is to disseminate information broadly to facilitate accurate and effective assessment practices in long term care facilities. This is an adjunct to the Long Term Care RAI User's Manual, Version 2.0, Oct. 1995.

A copy of CMS' Long Term Care Resident Assessment Instrument User's Manual Version 2.0 can be downloaded for free from the CMS web site at:

www.hcfa.gov/medicaid/mds20/man-form.htm

The manual is listed as "MDS 2.0 Training Manual", filename manual.exe. Due to the format and size of this file, printing the User's Manual may be complicated and time consuming. It may be easiest to purchase a bound copy. Bound copies can be purchased for \$84.00 (plus s + h), from National Technical Information Services, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161, tel. (800)-553-6847, order publication number PB-96-109053. Bound copies are also sold by various national associations, and by commercial vendors of forms and manuals.

The Q & A's in this document were developed by CMS Central Office staff: Cindy Hake, Dana Burley, Sheila Lambowitz, and Jeane Nitsch; with editorial review by CMS staff: Lisa Hines, Yael Harris, Dorothea Musgrave and Rosalind Abankwah, Pharm.D. Special thanks are given to Dr. John Morris, Dr. Katharine Murphy, and Pauline Belleville-Taylor of the Hebrew Rehabilitation Centre for the Aged; and to Dr. Bob Godbout of Stepwise Systems, Helen Deere-Powell, Pharm.D., (CMS expert consultant), Carmen Bowman (Colorado State Agency), and Sheri Kennedy of Knowledge Solutions, for their input on these materials.

Please refer any additional MDS clinical or coding questions to the RAI Coordinator in your State, and any additional questions regarding MDS automation and electronic transmission to the MDS Automation Coordinator in your State. A list of State RAI and MDS Automation Coordinators, including contact information, is published on the CMS website at:

www.hcfa.gov/medicaid/mds20/state.htm/

MDS Questions that cannot be resolved at the State level should be referred by the State to the CMS Regional Office RAI Coordinator. MDS Questions that cannot be resolved at the Regional level should be referred by the Regional Office to the CMS Central Office: MDS Coordinator

Center for Medicaid and State Operations
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop S2-12-25
Baltimore, MD 21244

PPS questions should be referred to the facility's Medicare Fiscal Intermediary.

Thank you for your continued enthusiasm in implementing the RAI version 2.0.

General Questions about the RAI Process

QUESTION 3 - 1: Is it necessary to actually observe and physically assess the resident, conduct family interviews, staff interviews, etc., every time we perform an MDS assessment? Most of our residents have been with us for several years, as has the staff, so we really know how our residents' status.

It is important to observe, interview and physically assess the resident, and to interview staff. In addition, the MDS was designed to consider information obtained from family members, although it is not necessary that every discussion with them be face-to-face. Assessors should capture information that is based on what actually happened during the observation period, not what usually happens. Problems may be missed when the resident's actual status over the entire observation period is not considered.

QUESTION 3 - 2: During orientation to my position I was told that I could answer the questions on the MDS by looking at the clinical record. Recently someone mentioned that I should interview staff from all shifts. Which is correct?

Review the RAI Users' Manual Version 2.0, pg. 2 – 19, 20. Assessors must capture the resident's actual status and performance, and what care was actually provided during the entire observation period. This includes gathering information from a variety of staff and/or gathering information across shifts, when indicated by the MDS Item coding instructions. Not every nuance will be documented in the clinical record. Therefore it's important to obtain information from the residents and direct care givers. To code the MDS accurately, multiple sources of information must be used, such as: interview, observation and assessment of the resident, communication with direct care staff and other disciplines working with the resident, contact with family, and clinical record review. It is not necessary that one assessor must do all of this him/herself. It's up to the facility to establish systems, policies and procedures to facilitate the RAI processes, and accurate MDS coding.

QUESTION 3 - 3: If an Item does not trigger, or has no associated trigger, but is viewed by the interdisciplinary team as a resident problem, is there a requirement to care plan for that problem?

Yes. The RAI was not designed to identify every conceivable problem that a resident might experience. An example of this is "chewing problem" at MDS Item K1a. Although the resident might have a chewing problem, checking this problem does not trigger a RAP. Clinical judgment must be exercised in the identification of problems and potential problems in developing the plan of care.

In ensuring that a resident's care plan is unique and specific to the resident, it is not sufficient to rely solely on the triggered RAPs.

QUESTION 3 - 4: Can a facility use the therapy evaluation done in the hospital to start the SNF therapy plan of care?

No. The beneficiary's needs and goals during an acute care hospital stay are not necessarily the same as those that will be established during the SNF stay. Although the physician and therapist should review the hospital evaluation if available, the therapist **MUST** perform a full evaluation of the beneficiary as he/she presents in the facility. The plan of treatment is then developed by the physician and the therapist to address the beneficiary's needs and goals during the post-acute stay at the SNF.

QUESTION 3 - 5: In the Medicare Prospective Payment System (PPS) Final Rule, as well as in the State Operations Manual (SOM), reference is made to a "look-back" period. Reference is also made in PPS documents to an "assessment period". Are the "look-back" and "assessment period" the same as the "observation period"?

Yes. The observation period, as defined in the CMS Long Term Care Resident Assessment Instrument User's Manual Version 2.0, pg. 3-29 – 3-31, is the same as the look-back and the assessment periods. It is the time period during which data may be captured for inclusion in an MDS assessment. The last day of the observation period is the Assessment Reference Date (the date recorded at MDS Item A3a).

QUESTION 3 - 6: Is the observation period always 7 days for every Item on the MDS?

No. The observation period varies by Item. It can be as short as 3 days, (e.g. MDS Item J1d), or as long as 180 days (e.g. MDS Items J4b, c and d). When the observation period is not indicated on the form at the specific MDS Section or Item, use a 7-day observation period. Note the statement at the top of the MDS form "status in the last 7 days, unless other time frame indicated". Regardless of the length of the observation period, it always ends on the assessment reference date, (the date recorded at MDS Item A3a).

QUESTION 3 - 7: We discovered an assessment that was signed and dated by all assessors, but not by the RN Coordinator. The RN Coordinator employed at the time of that assessment is no longer at the facility. Can the new RN Coordinator sign the assessment at MDS Item R2a?

Yes. If all individual assessors have signed the assessment, and attested to it's accuracy, all that remains is for the RN Coordinator to review for completeness, and sign and date the assessment at Items R2a and b. The date at R2b must be the date the RN Coordinator actually signed the form. Backdating is not permissible.

QUESTION 3 - 8: Please clarify the signature and date requirements for assessments that are printed after being encoded in the computer. Specifically, when we take the allowed 7 days to encode the data in the computer, what date should we use on the printed assessment?

Each assessment must be completed, and a paper copy signed, within the federally mandated timeframe, whether this is a hand written or a computer generated form. For example, an initial admission assessment must be completed through MDS Item VB2, signed and dated, no later than day 14 of the stay. An additional 7 days after completion are allowed to encode, edit, and correct the assessment. Any corrections during this period must be made to the electronic and the paper records in the facility. It may also be appropriate to update the resident's care plan, based on the revised assessment record. To make the correction on the paper form, the person responsible for the accuracy of the information enters the correct response, draws a single line through the previous response without obliterating it, and initials and dates the corrected entry. CMS has published this information in the State Operations Manual, page R-161. It is also published in CMS' "Draft Provider Instructions for making Automated Corrections Using the New MDS Correction Request Form", page 2-12, under the heading "Assessment Error Detected During the 7 Day Editing Period".

QUESTION 3 - 9: I thought we had 7 days after an assessment was completed to correct any errors and encode an assessment. In our facility, we print and sign the assessment by day 14. Does this mean that we lose that "additional 7 days"?

An additional 7 days following completion are always available for the facility to edit and correct the assessment. If an assessment is printed and then signed as complete by day 14, then you do not lose the additional 7 days after completion for editing and correcting the assessment.

QUESTION 3 - 10: Must a facility maintain both the hand written and computer-generated MDS forms on the resident's clinical record? If not, which is preferred?

Not every facility prints computer generated resident assessment records. In some facilities, the records are manually completed. There is no requirement to maintain two copies of the form in the resident's record. Either a hand written or a computer-generated form is equally acceptable. It is required that the record be completed, signed and dated within the regulatory timeframes, and maintained for 15 months in the resident's active record. If changes are made after completion, those changes must be made to the electronic record, and indicated on the form using standard medical records procedure. It may also be appropriate to update the resident's care plan, based on the revised assessment record. Resident assessment forms must accurately reflect the resident's status, and agree with the record that is submitted to the CMS standard system at the State. For additional information, refer to Resident Assessment Requirements for Long Term Care Facilities in the Code of Federal Regulations at 42 CFR 483.20.

QUESTION 3 - 11: Is it permissible to use electronic signatures for RAI forms and maintain RAI records only in electronic format?

Until such time as the agency adopts an electronic signature standard that is compatible with pending Health Insurance Standards and Accountability Act (HIPAA) requirements for electronic signature, all facilities are required to sign and retain hard copies of MDS forms. We understand that the industry is eager to use electronic signatures, and we are just as eager to enable that capability. We plan to implement this as soon as the agency adopts an electronic signature standard, and the standard system is upgraded to enable compliance.

Questions on Items in MDS Section AA of the Basic Assessment Tracking Form, Including Questions Related to Reasons for Assessment, Timing and Frequency Requirements, RUG-III and Medicare Billing

QUESTION 3 - 12: How is the interval between quarterly assessments calculated?

The federal requirement at CFR 483.20 (c) specifies that Quarterly Review assessments must be conducted "not less frequently than once every three months". Timing edits in the MDS standard system count 92-day intervals, because there are never more than 92 days in any consecutive three-month intervals. These 92 days are measured from the date at MDS Item R2b of one assessment to the date at Item R2b of the next. In other words, there can be no more than 92 days between the dates recorded at MDS Item R2b of the last to

the next clinical assessment. This information can be found on CMS ' MDS web site, in the MDS data system specifications:

1. Go to: www.hcfa.gov/medicaid/mds20/mdssoftw.htm.
2. Click on: "Version 1.10 Files Available for Downloading".
3. Click on to download the file: mds110.exe
4. Click on the download mds110.exe file to extract the document spdoc110.pdf (this is a document providing general data specifications information).
5. Review the "Record Timing" timing topic in spdoc110.pdf

CMS has also published a clarification specifying the 92-day interval in our State Operations Manual.

QUESTION 3 - 13: If an assessment shows that the beneficiary's RUG-III group has changed, should the assessment be coded as a Significant Change in Status Assessment (SCSA)?

Not necessarily. A SCSA may be coded as the Reason for Assessment ONLY when a resident has experienced a significant change in condition. A change in a RUG-III group does not by itself constitute a significant change in condition. Conversely, a significant change in condition may or may not cause a change in a RUG-III group. There is no direct relationship between the two. For information on assessing for significant change see: "Guidelines for Determining Significant Change in Resident Status", beginning on page 2-8 in the CMS' Long Term Care Resident Assessment Instrument User's Manual, Version 2.0 published October 1995.

QUESTION 3 - 14: A Medicare assessment was done on day 57 of the stay for a Part A beneficiary. This was the beneficiary's first stay in the facility. The beneficiary's Part A stay ended on day 67. The resident was not discharged from the facility. Is the OBRA quarterly assessment due 92 days from the completion date of the initial admission assessment? Or is it due 92 days from the completion of the Medicare 60-day assessment?

The Medicare assessment schedule does not affect the OBRA assessment schedule. In the above scenario, the next scheduled OBRA assessment is a Quarterly assessment, and it must be completed no later than 92 days from the date recorded at Item R2b of the last OBRA assessment, which was the initial admission assessment.

To minimize assessment burden, facilities may complete one assessment to satisfy both a payment and an OBRA requirement, provided that the assessment meets the criteria specified under both the payment and the clinical rules. The Medicare 60-day assessment can also be coded as the OBRA quarterly

assessment, provided that

- the care plan is reviewed, and updated if appropriate, in accordance with clinical requirements; and
- the assessment include both the items required for the quarterly MDS, and all portions specified for the full, PPS assessment, including Section S. Note that the full assessment contains all items in any of CMS' standard quarterly assessments.

When a quarterly assessment is completed early, the facility may need to adjust the schedule for future assessments in order to ensure that there is not more than 92 days between any two OBRA assessments. The following date requirements must be adhered to when scheduling OBRA required assessments:

- No more than 92 days between ANY two OBRA assessments. This is measured from the completion date recorded at MDS Item R2b on the last OBRA assessment to the completion date at R2b of the current OBRA assessment; AND
- No more than 366 days between any two comprehensive OBRA assessments, (i.e., Initial Admission, Annual, Significant Change, or Significant Correction of Prior Full assessment). The 366 days is measured from the completion date recorded at MDS Item VB2 on the last comprehensive assessment to the completion date at VB2 of the current comprehensive assessment.

QUESTION 3 - 15: When a resident experiences a significant change, how many days does the facility have to complete a Significant Change in Status assessment (SCSA) for SNF PPS?

The rules governing the SCSA are unchanged by PPS. A Significant Change in Status assessment should be performed as soon as needed to provide appropriate care to the individual, but in no case, later than 14 days after the determination is made that a significant change has occurred. This information is provided on page 2-8 of the RAI User's Manual.

If the SCSA results in a change in the RUG-III group, the new payment rate will be effective on the earlier of the Assessment Reference Date of the SCSA or, if the SCSA replaces a regularly scheduled PPS assessment, the first day of the next SNF PPS payment period.

QUESTION 3 - 16: What are the grace days for a Medicare 14-day assessment (AA8b = 7) that is also an initial admission assessment (A8a=1)?

Any time an assessment is completed to satisfy requirements for both a Medicare and a clinical assessment; the assessment must meet the criteria specified under both the payment and the clinical rules. Under Medicare PPS rules, the allowable Assessment Reference Dates for the Medicare 14-day assessment are days 11 through 14, with up to 5 grace days, which could extend the Assessment Reference Dates from day 15 to day 19. The timing rules for the initial admission assessment do not permit the Assessment Reference Date or the completion date to be later than the 14th day of the stay. Therefore, when these two assessments are combined, no grace days can be used.

QUESTION 3 - 17: A Medicare beneficiary's therapy is discontinued, but the beneficiary remains eligible for Part A services. The Other Medicare Required Assessment (OMRA) is done timely. A few days later, the beneficiary again becomes able to participate in therapy. How does the facility code the next MDS and when would it be done?

Initiation or return to therapy, is not, by itself, a reason to complete a new assessment; however, a significant change in condition may have contributed to the resident commencing therapy. Provided that the resident has not experienced a significant change in status, the facility would continue to perform MDS assessments in accordance with the Medicare schedule. The MDS would be coded as the 5, 14, 30, 60 or 90-day assessments, as appropriate.

Please note that the facility needs to assess the resident using the guidelines provided in the RAI User's Manual beginning on page 2-8 for guidance in determining whether a significant change has occurred.

QUESTION 3 - 18: Do hospitalizations affect the timing of the Medicare PPS assessments?

Yes. As shown in the example below, inpatient hospitalizations restart the SNF PPS assessment schedule.

Example:	
Admitted to SNF:	March 1
Discharged to hospital:	March 4
Returned to SNF:	March 7

Staff should make every effort to complete a 5-day assessment for SNF PPS billing purposes. The assessment reference date may be no later than March 4. Without this assessment, the SNF would have to bill at the default rate from March 1-March 4.

When the beneficiary returns on March 7, the Medicare assessment schedule

starts over with a readmission/return assessment (A8b=5). The assessment reference date must be within 8 days of the return (i.e., within 5 days of the reentry plus 3 grace days).

The schedule for the Medicare 14-day assessment will be determined using the reentry date (March 7) as day 1.

Instructions concerning the impact of hospitalization on the timing of the OBRA Initial Admission assessment appear on page 2-7 of the RAI User's Manual. "If a resident goes to the hospital and returns during the 14 day assessment period and most of the initial assessment was completed prior to the hospitalization, then the facility may wish to continue with the original assessment, provided the resident did not have a significant change in status. Otherwise the assessment should be reinitiated and completed within 14 days after readmission from the hospital. The portion of the resident's record that was previously completed should be stored on the resident's record with a notation that the assessment was reinitiated because the resident was hospitalized."

To minimize assessment burden, the facility may combine the Initial Admission assessment with either the Medicare 5-day Reentry assessment, or the Medicare 14-day assessment.

QUESTION 3 - 19: Must RAPS be completed with Medicare assessments?

RAPs are not required for Medicare assessments. RAPs are ONLY required for comprehensive clinical assessments. However, when a Medicare assessment is combined with a comprehensive clinical assessment, the RAPs must be completed in order to meet the requirements of the comprehensive clinical assessment. Comprehensive clinical assessments are identified at MDS Item AA8a, and include only the following four Reasons for Assessment:

Admission (AA8a = 1)

Annual (AA8a = 2)

Significant Change in Status Assessment (AA8A = 3)

Significant Correction of Prior Full (read "full" as "comprehensive") Assessment (AA8a = 4)

QUESTION 3 - 20: What MDS records are required when a resident returns to the facility following a hospital observational stay of less than 24 hours?

For hospital observational stays of less than 24 hours, the resident stays on the previously established clinical and PPS assessment schedule, unless the resident experienced a significant change. If a significant change occurred, the facility should complete a significant change assessment.

The response to this question can also be found in Exhibit 260 in the State Operations Manual: "MDS 2.0 Discharge and Reentry Flowchart", available on the CMS website at:

www.hcfa.gov/pubforms/transmit/2000/transmittals/comm_date_dsc.htm

and cited in the CMS' RAI Version 2.0 Q&A's, March 2001, question 2 – 6, at: www.hcfa.gov/medicaid/mds20/default.htm.

QUESTION 3 - 21: Can a facility complete the OBRA Quarterly assessment early, in order to combine it with the Medicare 60-day assessment?

Yes. When the first quarterly assessment is completed early, and combined with the Medicare 60-day assessment, future assessment requirements can be satisfied in one the following ways:

- Complete two more quarterly assessments no more than 92 days apart, and an annual assessment no more than 92 days after the third Quarterly. Using this option, the facility completes the annual assessment early, in order to meet the 92-day requirement; OR
- Complete three more quarterly assessments within 92 days of each other, and an annual assessment within 366 days of the last comprehensive assessment. Using this option, the facility completes an extra quarterly assessment, in order to meet the 92-day requirement.

QUESTION 3 - 22: If we complete one assessment to satisfy requirements for both an OBRA Quarterly and a Medicare PPS assessment, which assessment form should we use? The Quarterly assessment form? Or the full assessment form?

When a facility uses one assessment to satisfy requirements for both an OBRA and a Medicare PPS assessment, the facility must comply with both sets of rules. When a Quarterly and a PPS assessment are done in combination, use the full assessment form, because it contains all the portions of the MDS required for payment, and it also contains all of the Items on any of CMS' standard Quarterly assessment forms. Also be sure to review the care plan, and update it if appropriate, to satisfy the care plan component of the Quarterly assessment. In this scenario, use code "5" (Quarterly) at MDS Item AA8a, and also code the appropriate Medicare Reason for Assessment at Item AA8b.

In a separate but related scenario, a facility may also combine a comprehensive OBRA assessment with a Medicare PPS assessment. In that case, the full assessment, plus the RAPs and care plan component, must all be completed. When the comprehensive assessment is an initial admission assessment, the

Background (Face Sheet) information (Sections AA through AD) must also be completed.

QUESTION 3 - 23: If a Significant Change in Status Assessment (SCSA) for a Medicare Part A covered stay is done outside a Medicare assessment window and changes the RUG-III group, is that SCSA used in billing?

Yes. If an SCSA is required and it results in a different RUG III group, a bill must be sent to Medicare. The SCSA is considered an off-cycle Medicare assessment. The SNF should bill the new RUG-III group effective on the earlier of the assessment reference date (ARD) of the SCSA, or, if the SCSA is also a replacement for a regularly scheduled PPS assessment, the first day of that PPS payment period.

The payment will stay in effect until the beginning of the next payment period, or the ARD of the next off-cycle assessment (i.e., another SCSA, an Other Medicare Required Assessment (OMRA) or a Significant Correction of Prior Assessment (SCPA)), whichever is earlier.

QUESTION 3 - 24: How should Item AA8b be coded for an Other Medicare Required Assessment (OMRA)...

A. When the Assessment Reference Date (ARD) is within the assessment window of a scheduled Medicare assessment?

When the ARD of the OMRA falls within the assessment window of a scheduled PPS assessment, use code "8" at MDS Item AA8b. The HIPPS assessment indicator code will alert the FI that this also serves as a scheduled PPS assessment.

B. When it is NOT within an assessment window of a scheduled Medicare required assessment?

Also code AA8b "8" (OMRA) when the ARD of the OMRA does NOT fall within the assessment window of a scheduled PPS assessment.

C. When it is also a Significant Change in Status Assessment (SCSA)?

When an OMRA is also a SCSA, use code "3" (Significant Change) at MDS Item AA8a, and code "8" (OMRA) at MDS Item AA8b.

D. When it is NOT a SCSA?

When the OMRA is NOT also a SCSA, use the appropriate code at MDS Item AA8a (depending on whether this PPS assessment is combined with any other type of clinical assessment), and code "8" (OMRA) at MDS Item AA8b.

For more information on billing instructions, refer to Program Memoranda A0047 and A0156, available on CMS' website at:

www.hcfa.gov/medicare/snfpps.htm

QUESTION 3 - 25: If an Other Medicare Required Assessment (OMRA) is also a significant change in Status Assessment (SCSA), do you use the OMRA time frames, (e.g., 8-10 days after therapy is discontinued), or the SCSA time frame, (e.g., 14 days from the date staff identifies the significant change)?

Any time an assessment is completed to meet requirements for both a Medicare and a clinical assessment; both sets of rules must be followed. The Medicare rules require that an OMRA assessment be performed for residents who continue to require skilled services using an Assessment Reference Date (at Item A3a), that falls on the 8th, 9th or 10th day after all therapies have been discontinued. The clinical rules require that a SCSA be completed at MDS Item VB2 within 14 days of identifying the change. A comprehensive assessment (including RAPs and Care Planning); that uses an assessment reference date of day 8, 9 or 10; and that is completed within 14 days of the date the determination was made that as Significant Change occurred; satisfies both the Medicare and the OBRA timing requirements.

QUESTION 3 - 26: Does the facility need to complete and transmit a discharge tracking form if the resident's bed is being held?

The requirements for completion of a Discharge Tracking form are not associated with bedhold status. A Discharge Tracking form is required whenever a resident is discharged, regardless of bedhold status. If the bed is being held, it logically follows that return is anticipated, and Item AA8a on the Discharge Tracking form is coded "7" (return anticipated).

QUESTION 3 - 27: Is it necessary that a resident have a bedhold in order to code Item AA8a on the Discharge Tracking form "7" (return anticipated)?

No.

QUESTION 3 - 28: Should Item AA8a (Reason for Assessment) be coded "8" (discharged prior to completing initial assessment) even when the resident is not returning, e.g., the resident died or was transferred to another facility)?

Yes. Even when you know that the resident is not returning, if the initial Admission assessment, (MDS Item AA8a = 1), has not been completed, a Discharge Tracking form is required. In this case, Item AA8a should be coded "8" (discharged prior to completing initial assessment). This is true regardless of the reason for the discharge. It is also true regardless of whether the Medicare 5-day assessment was completed. Additional guidance for coding Item AA8a in the event of discharge and reentry can be found in Exhibit 260 in the State Operations Manual: "MDS 2.0 Discharge and Reentry Flowchart". This flowchart is available on the CMS website at:

www.hcfa.gov/pubforms/transmit/2000/transmittals/comm_date_dsc.htm

and cited in the CMS RAI Version 2.0 Q&A's, March 2001, question 2 – 6, at:

www.hcfa.gov/medicaid/mds20/default.htm

Questions on Items in MDS Section AC

QUESTION 3 - 29: Who is responsible for completing Section AC1, Customary Routine?

Facilities have flexibility in determining who should participate in the assessment process as long as the MDS 2.0 is accurately conducted. A facility may assign the Customary Routine section to one person or to several members of the interdisciplinary team. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment. All staff who completed any part of Sections AA - AC must sign their names and identify the sections they have completed in Section AD. Refer to the information under "Participants in the Assessment Process" on page 2-16 of the RAI User's Manual.

QUESTION 3 - 30: What is the purpose of obtaining the information needed to complete Section AC1 Customary Routine?

Engaging the resident and or the family member in a discussion about the resident's routines in the year prior to the date of entry is an excellent means of obtaining important information and starting the therapeutic relationship between facility clinicians and the resident and family. Information about the resident's prior routines in areas such as bathing, dietary preferences, and usual social activities or hobbies can be used by the facility staff to develop a care plan that is specific to that resident's needs and preferences. Through the completion of Section AC, the nursing home staff begins the assessment of areas such as speech patterns, hearing, vision, cognition, decision-making, and others.

Questions on Items in MDS Section B

QUESTION 3 - 31: Regarding MDS Item B2a, (Short-term memory – OK), if a resident independently arrives to all scheduled meals on time, is this enough evidence to conclude that the resident's short-term memory is OK?

No. Many persons with memory problems can learn to function successfully in a structured, routine environment such as a nursing facility. Observing resident function in multiple daily activities is only one aspect of evaluating short-term memory function, but is an important component for assessing MDS Item B4, Cognitive Skills for Daily Decision Making. MDS Item B2a focuses on a specific aspect of cognitive function called "short-term memory" and directs you to determine if the resident seems or appears to recall (what was learned or known) after 5 minutes. Nursing facility staff are very familiar with residents who may function well in daily activities but cannot remember what staff told them or what happened 5 minutes ago. For example, a resident may remember to come to lunch but may not remember what he ate. As described in the RAI User's Manual (pp. 3-41 to 3-43), use a direct approach to test short-term memory during a conversation with the resident. The following test is excerpted from the User's Manual, page 3-43.

Ask the resident to remember three items (e.g., book, watch, table) for a few minutes. After you have stated all three items, ask the resident to repeat them to you (to verify that you were heard and understood). Then proceed to talk about something else — do not be silent, do not leave the room. In five minutes, ask the resident to repeat the name of each item. If the resident is unable to recall all three items, code "1."

QUESTION 3 - 32: If a resident's short-term memory function fluctuated throughout the 7-day observation period, how should Item B2a be coded?

The intent of this Item is to identify the resident's assets and strengths so that the health care team can draw upon these strengths in developing a care plan. Code the resident at his/her highest level of functioning. During the 7-day assessment period, give the resident the simple short-term memory test described in the RAI User's Manual, page 3-43 (below). If the resident's short-term memory fluctuates, staff may re-test the resident, and in order to give the resident the benefit of the doubt, use the best test as a basis for coding Item B2a.

Ask the resident to remember three items (e.g., book, watch, and table) for a few minutes. After you have stated all three items, ask the resident to repeat them to you (to verify that you were heard and understood). Then proceed to talk about something else — do not be silent, do not leave the room. In five minutes, ask the resident to repeat the name of each item. If the resident is unable to recall all three items, code “1.”

Questions on Items in MDS Section D

QUESTION 3 - 33: For the purpose of coding MDS Item D1 (Vision Patterns), is it necessary to use an eye chart to test the resident's vision?

It is not necessary to use an eye chart to test a resident's vision. However if an eye chart is used, the results of the eye exam may be used in coding Item D1.

The recommendation in the RAI User's Manual (pages 3-55 and 3-56) is to ask the resident to read material that is regular size newsprint. If the resident can not see this, then the assessor moves on to large print text. It is difficult to identify and assess residents who cannot read in English, or to identify and assess residents who may not be able to read in their primary language. Such residents may be asked to identify numbers, shapes or symbols in the two sizes (equivalent to regular and large print).

For residents who do not have the ability to see small objects and who are unable to participate in the eye testing described above, the assessor needs to conduct his or her own observation during the assessment process. Information may also be obtained by consulting with other staff who may be familiar with the resident's visual acuity.

Questions on Items in MDS Section E

QUESTION 3 - 34: It is difficult to track all the signs and symptoms at Items E1a-p, (Indicators of Depression, Anxiety, Sad Mood) over the 30 day observation period. Do you have suggestions for monitoring them?

The keys to obtaining, tracking and recording accurate information in Section E are 1) interviews with and observations of residents, and 2) communication

between licensed and non-licensed staff and other caregivers (See RAI User's Manual p.3-58).

- Daily communication between nurses, certified nurse assistants (CNAs) and other direct care providers is crucial for resident monitoring and care giving.
- The Mood Items specify a 30-day observation period. Try a rule-out process to make coding easier. For each indicator listed, think about whether it occurred at all. If not, use code "0". If the resident exhibited the behavior almost daily (6, 7 days/week) or multiple times daily, code "2". If codes "0" or "2" do not reflect the resident's status, but the behavior at least once, use code "1".
- Educate all caregivers (including direct care staff) about the residents' status in this area, and how to observe mood and behavior patterns that are captured in Section E of the MDS. These mood and behavior patterns are not part of normal aging. They are often indicative of depression, anxiety, and other mental disorders. These conditions are often under-identified and under-treated or untreated in nursing homes. Part of the reason may be that staff tend to perceive them as the residents' "normal" or "usual" behaviors.
- Documentation of signs and symptoms of depression, anxiety and sad mood, and of behavioral symptoms, is a matter of good clinical practice. This information facilitates accurate diagnosis and identification of new or worsening problems. It should be used in planning and individualizing appropriate care and treatment. This information facilitates communication to the entire treatment team, across shifts, and is necessary in order to monitor, on an on-going basis, the resident's status and response to treatment. It is up to the facility to determine the form and format of such documentation.

QUESTION 3 - 35: In my facility the social worker completes Section E. The nurses have noticed that signs of depression and behavioral problems are sometimes coded as "Not present", even when they have observed them occurring. The social worker said that if there is no documentation that the behavior occurred, she must code it as "not present". Does this mean that staff must document occurrences of behavior that is captured in Section E?

Any person completing this, or any other MDS section, is required to follow the Item-by-Item guidelines in the RAI User's manual that specify sources of information necessary for accurate coding. For this section, the process of information gathering should include direct observation of the resident; communication with the resident's direct caregivers across all shifts; review of relevant information in the resident's clinical record; and if possible, consultation with family members who have direct knowledge of the resident's behavior in the

observation period. Refer to the RAI User's Manual, page 3-58 through 3-68. If the person completing the MDS did not personally observe the behavior, but others report that it occurred, the behavior must be considered as having occurred when completing the MDS form. In addition, the resident's clinical record should support their status as reported on the MDS.

QUESTION 3 - 36: Regarding MDS Section E (Mood and Behavior Patterns), when a resident has exhibited several indicators of depression or anxiety for 2 years (i.e., daily negative statements, persistent anger with others, insomnia) do we still need to record these behaviors on the MDS assessment? The resident's psychiatrist tells us these signs are consistent with her disease and there is nothing more we can do to minimize them.

Documenting chronic mood and behavioral symptoms is no less important than documenting chronic physical problems such as chest pain, shortness of breath or recurrent lung aspirations. The MDS provides a perspective of how the resident functions now, and over the entire course of the stay. All active signs of mood or behavioral problems specified in Section E must be accurately documented on the MDS, even if all appropriate pharmacological and non-pharmacological interventions have been tried and this is the best level of function that can be achieved for this resident. Symptoms that cannot be lessened are no less important when considering the resident's overall health status. In fact, such symptoms may impact other health issues.

QUESTION 3 - 37: My staff is concerned that they are "labeling" the resident as being "depressed" or "anxious" when coding indicators at Section E of the MDS. Is this so?

Coding the presence of indicators in Section E does not automatically mean that the resident has a diagnosis of depression or anxiety. Assessors do not make or assign a diagnosis in Section E. They simply record the presence or absence of specific indicators and behaviors. It's important that facility staff recognizes these clinical indicators, and consider them when developing the resident's care plan. When indicators are present, Section E Items serve as triggers for the interdisciplinary team to consider the appropriate RAP(s). Upon review of the RAP guidelines, the interdisciplinary team makes decisions about the need for further evaluations, referrals, and diagnoses.

Questions on Items in MDS Section F

QUESTION 3 - 38: How do you determine whether a resident is “at ease” for the purpose of coding MDS Items F1b (At Ease Doing Planned or Structured Activities), and F1c (At Ease Doing Self-Initiated Activities)?

To code these Items, assess whether the resident is *involved*, and *takes initiative* in participating in social and recreational programs, including solitary pursuits.

Item F1b, “At Ease Doing Planned or Structured Activities”, should be checked for a resident who is comfortable with, or doesn’t feel restricted by planned or structured activities, for example, a resident who pursues activity programs, seems content to be involved, and takes initiative in participating. This Item should be left blank for a resident who is not at ease with planned activities, for example, a resident who is unable to sit still during activities, or who is disruptive, attempts to leave, or refuses to attend.

Item F1c, “At Ease Doing Self-Initiated Activities”, should be checked for

residents who are able to occupy at least some of their leisure time with meaningful, self-directed activities. Such residents find things to do to occupy themselves, like reading a book, organizing their belongings, visiting other residents, writing letters or making phone calls. This Item should be left blank for residents who are not at ease doing self-initiated activities. Such residents may spend most of their time alone and unoccupied, or are dependent on others to occupy their leisure time. For these residents, there is no element of self-direction or self-initiation in activity involvement.

Coding instructions for Items F1b and c appear on pages 3-68 to 69 of the RAI User’s Manual.

QUESTION 3 - 39: Regarding MDS Item F1b (At Ease Doing Planned or Structured Activities), how is a cognitively impaired resident assessed for being “at ease”?

A cognitively impaired resident participating in organized social or recreational activities may show signs of being “at ease” with the activity by smiling; making eye contact with the activity leader; actively participating in the activity (singing, dancing, tapping, clapping); and if not actively participating, then the resident may be sitting or standing quietly during the activity. A resident who is not “at ease” during an activity might cry or call out during the activity; repeatedly try to get up to leave the activity and not respond to gentle cueing to return to participation in the activity; shout or strike out at staff or other residents.

Questions on Items in MDS Section G

QUESTION 3 - 40: Should a therapist complete Section G (Physical Functioning and Structural Problems)?

Facilities have flexibility in determining who should participate in the assessment process as long as the MDS 2.0 is accurately conducted. The RAI instructions do not specify which discipline must complete any section of the MDS. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment. Facilities are responsible for assigning a qualified person to complete a specific section or sections of the MDS 2.0 Assessment. Refer to the information under "Participants in the Assessment Process" on page 2-16 of the RAI User's Manual.

QUESTION 3 - 41: We have trouble collecting data to accurately code ADLs and differentiating between levels of assistance. Do you have any suggestions to simplify this data collection process?

The key to ADL coding is the concept of three events. First the assessor determines whether the resident has been totally dependent. For a resident to have a code of totally dependent for ADLs, each time the activity occurred the resident had to be totally dependent (did not contribute to the activity at all), there were no exceptions. As soon as the resident did some part of the activity, the resident was not totally dependent. For all other categories, the clinician is reviewing for the most dependent activity that occurred at least 3 times in the last 7 days. Knowing the total number of times the activity occurred is not necessary for scoring accuracy. Knowing whether the activity occurred 3 or more times in the last 7 days is key to ADL coding accuracy.

The ADL coding was created to reflect real situations in nursing homes, where small variations in performance are common. For example, in scoring a resident as independent in ADL self-performance, there can be 1 or 2 exceptions. As soon as there are 3 exceptions, the resident is not independent, and you need to consider another code. Staff who are new to conducting MDS assessments need to become familiar with the coding structure, and how exceptions are handled. Codes of 0, 1, 2, 3, (Independent, Supervision, Limited Assistance, and Extensive Assistance) have been designed to allow one or two exceptions for the provision of assistance from the staff helper.